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Susan J. Barnett, LCSW, Informed Consent/Payment Policy Statement

Thank you for deciding to seek counseling with Susan Barnett. The following information will help you understand many of the details about your therapy here. We are a private practice group of therapists offering Christian counseling and coaching. We seek to help hurting people recognize, understand, and solve their problems in accordance with the Word of God.

Therapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Please understand that your Therapist is in private practice and is not available on a 24-hour basis, seven days a week. Consequently, if you are unable to reach them, you can contact the HELP LINE at (270) 843-HELP or proceed immediately to the nearest local emergency room. We have listed below our various office policies for your information. Please read through these, ask any question you may have and sign below. Thank you for allowing us to serve you.

SESSIONS

Sessions are typically scheduled for 45-60 minutes at a frequency to be determined by the counselor and client. You and your counselor will work together to develop goals on which you want to work. Your counselor cannot change you, but acts as a facilitator.

PAYMENT POLICY

Ms..Barnett will see clients on a fee-for-service basis only. The client/parent is responsible for payment in full at the time of each session with a charge of $125.00 per forty five to sixty (45-60) minute sessions. Our policy is for each person receiving counseling or testing services to pay for such service at the time the professional services are rendered. Any other arrangements must be made in advance. A $25.00 administrative fee will be charged on all checks that are returned for non-sufficient funds.

Phone consultations are billed in 15-minute increments ($27.50 minimum). In case of emergency, please call 911.

INSURANCE

I authorize this agency, to file my insurance and authorize them to provide the necessary diagnostic/treatment information, as well as any information related to my therapy that my insurance company and/or managed care organization may require. Susan Barnett, LCSW is required to make a medical diagnosis for insurance billing purposes. Sharing of medical information can potentially affect your rates of insurability. If you wish to avoid disclosure of personal treatment information to your insurance company, you have to right to privately pay for your services with our office.

CONFIDENTIALITY

I understand that all communications between my therapist and myself are confidential and will not be shared with anyone unless I have signed a release of information, except in the following circumstances:

- If you, a child, or elderly person is being emotionally, sexually, or physically abused or neglected;
- If the client or someone the client mentions is a serious threat to his/her own life or the life of another;
- If ordered to do so by a judge in a court of law.

In the aforementioned cases, the therapist is bound by state law to inform the appropriate authorities.

CANCELLATIONS

We understand that it may, at times, be necessary to cancel an appointment. To help us be most efficient and responsible in the use of our time, we require that any changes or cancellations be made at least 24 hours in advance. Any changed, cancelled, or missed appointment with less than 24-hour notice will be charged $55.00.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I have read the preceding information, and I understand my rights as a client. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services. My signature acknowledges agreement and understanding. Permission is hereby given to render treatment or service to:

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Signature of Client or Responsible Party Date

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Print Client Name Signature of Therapist